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Religious, Ethical and Legal Considerations in End-of-Life Issues: Fundamental Requisites for Medical Decision Making

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Abstract Religion and spirituality have always played a major and intervening role in a person's life and health matters. With the influential development of patient autonomy and the right to self-determination, a patient's religious affiliation constitutes a key component in medical decision making. This is particularly pertinent in issues involving end-of-life decisions such as withdrawing and withholding treatment, medical futility, nutritional feeding and do-not-resuscitate orders. These issues affect not only the patient's values and beliefs, but also the family unit and members of the medical profession. The law also plays an intervening role in resolving conflicts between the sanctity of life and quality of life that are very much pronounced in this aspect of healthcare. Thus, the medical profession in dealing with the inherent ethical and legal dilemmas needs to be sensitive not only to patients' varying religious beliefs and cultural values, but also to the developing legal and ethical standards as well. There is a need for the medical profession to be guided on the ethical obligations, legal demands and religious expectations prior to handling difficult end-of-life decisions. The development of comprehensive ethical codes in congruence with developing legal standards may offer clear guidance to the medical profession in making sound medical decisions.

Keywords End-of-life decisions · Religious considerations · Ethical dilemmas · Legal standards

Introduction

Technological and pharmacological advances in medicine have created more challenges to healthcare professionals as modern medical interventions progress to increase life

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expectancy of terminally ill patients. These life-prolonging measures have made end-of-life care an emerging aspect in the medical field. Decisions at the end of life are no longer confined to clinical assessments as to what would be in the best interests of the patient from a purely medical perspective, but involve due consideration of a patient's religious beliefs, customs and values, which ultimately have significant influence on a patient's response to illness, suffering and dying. Furthermore, the decision-making process also affects healthcare providers, particularly if the doctor and patient come from diverse cultural backgrounds and adhere to different sets of values. The conflicting ethical views and developing legal standards in this area on matters concerning the sanctity and quality of life, patient autonomy and medical paternalism have also made end-of-life decisions an ongoing debate (Agarwal and Murinson 2012; Billings and Krakauer 2011; Cantor 2005; Chin 2002; da Rocha 2009; Huxtable 2002; Kuhse 1981; Orentlicher 1998; Rabiou and Sugand 2014). In any event, all affected parties carry with them their own individual life experiences, values and beliefs to the decision-making process; accordingly, the event of death itself, the manner in which it takes place, and the patient's quality of life are significant matters that have spiritual and psychological consequences for each of them.

The Importance of Ethics, Religion and Law as Guidance for Medical Decision Making

Ethics is classified as a sub-branch of applied philosophy that is intrinsically related to morality (Padela 2007). The correlation between ethics and morality is that morality refers to social norms that distinguish from right to wrong, while ethics describes moral conduct based on the character and principles in each profession (Elsayed and Ahmed 2009). Medical ethics is a subdivision of ethics that is concerned with moral principles as they relate to biomedical science in the clinical and investigational arenas (Padela 2007). Ethical principles are essential in helping to guide medical judgements that need to be made and should be intrinsically linked to the application of clinical skills and knowledge, which are used for delivering what is in the best interests of the patient (Tallon 2012). Accordingly, medicine and morality are thus very much interrelated, as the primary function of medicine is not only "to cure illness...but to cure people of their illnesses" (Steinberg 2003). The importance of observing medical ethics can be outlined as follows: (1) ethical standards promote the aim of medical care; (2) medical care is built on the communication, trust and respect between the medical team on the one side, and the patient and/or family on the other side; (3) ethical standards help generate public support for healthcare; (4) public awareness and support for healthcare will promote ethical conduct by healthcare providers in the performance of their duties; and (5) ethical standards promote moral and social values and facilitate cooperation and collaborative work between different medical disciplines, leading to a healthy healthcare environment (Elsayed and Ahmed 2009). All existing medical codes of ethics directly and indirectly incorporate into their provisions the fundamental principles which form the ethical basis of medical care, i.e. autonomy, paternalism, non-maleficence, beneficence and justice.

In recognition of the fact that culture and its components of religion and spirituality constitute major social factors that greatly influence the provision of medical care, especially at the end of life, some countries have also expressly included these components in their ethical codes. For example, the Good Medical Practice: a code of conduct for doctors in Australia issued by the Medical Board of Australia ("GMC") contains provisions on "Culturally Safe and Sensitive Practice" which state that "good medical practice involves

genuine efforts to understand the cultural needs and contexts of different patients to obtain good health outcomes” which includes: (1) having knowledge of, respect for and sensitivity towards the cultural needs of the community that one serves, including those of indigenous Australians; (2) acknowledging the social, economic, cultural and behavioural factors influencing health, both at individual and population levels; and (3) understanding that one’s own culture and beliefs influence one’s interactions with patients (Medical Board of Australia n.d.; Medical Council of New Zealand 2013). Furthermore, in Clause 3.12 of the GMC, which deals with end-of-life care, respect and support for the values and wishes of the patient and family members are emphasised, including “different cultural practices related to death and dying” (Medical Board of Australia n.d.).

Cultural competence, i.e. the acquisition of the knowledge and skills that enhance the management of cultural issues in the clinical environment requires skilled verbal and non-verbal communication as a means of appreciating differences (Carey and Cosgrove 2006). Better healthcare especially at the end of life can only be achieved if these factors are given due consideration as medicine does not merely deal with elements of pure science, but also major and intrinsic humanistic and ethical components (Steinberg 2003). In Part 3 of the End of Life Care Strategy issued by the Department of Health in the UK (UK Department of Health 2008), guidelines are provided to address the spiritual needs of patients nearing the end of life. This is complemented by the NHS Chaplaincy (UK Department of Health 2003), which acts as a guidance to those involved in the provision of chaplaincy-spiritual services. It is submitted however that the content of the End of Life Care Strategy and NHS Chaplaincy, while respecting and recognising the importance of religious and spiritual considerations in end-of-life care, is not intended to specifically provide an understanding of the different values and beliefs on end-of-life issues. It is noteworthy that the Queensland Health Multicultural Services in collaboration with the Islamic Council of Queensland has published a series of handbooks for healthcare providers in attending to Muslim, Hindu and Sikh patients, respectively (Queensland Health and Islamic Council of Queensland n.d., 2010, 2011). Specific areas covered in the handbooks include religious approaches to end-of-life issues, pain management and the concept of death and dying. These are intended to support healthcare providers by building their knowledge of the diverse needs of their patients, noting that “those who display cross-cultural capabilities in their work use self-reflection, cultural understanding, contextual understanding, communication and collaboration to provide culturally appropriate, responsive and safe health care” (Queensland Health and Islamic Council of Queensland n.d., 2010, 2011).

In addition to the above, an integrated effort to develop a codified religious-based system of ethical conduct can also be seen in the form of the Islamic Code of Medical Ethics (First International Conference on Islamic Medicine 1981) (“Islamic Code”), which was drawn up and adopted at the First International Conference on Islamic Medicine in 1981. The Islamic Code aims to provide a guideline to Muslim doctors in understanding the tenets of Islam, which are relevant to the performance of their duties. The Islamic Code cites authorities from the *Shari’ah* and provides the Islamic perspective on an array of subject matters concerning medical care, including end-of-life issues such as the preservation of life, the refusal of a patient to a prescribed plan of treatment, medical interventions and futile therapy. In addition, the duty to respect the autonomy of the patient, as well as the obligation to ensure that harm is prevented (non-maleficence), and medical decisions are made to the benefit and best interests of the patient (beneficence), are inherent ethical values in the Islamic Code. The extent of application of the Islamic Code in healthcare policies and legislation of countries populated by Muslims, however, are of varying degrees from one country to the next.

In general, the majority of Arab countries emphasise the importance of healthcare professionals to respect human dignity, provide the best care available to patients and their families, as well as protecting their rights, safety and confidentiality (UNESCO Cairo Office 2011). Countries such as Jordan, Libya and Indonesia have gone further in their efforts to take steps to include guidelines pertaining to certain end-of-life decisions in their regulatory framework (Majelis Kehormatan Etik Kedokteran Indonesia 2001; UNESCO Cairo Office 2011), while in other countries such as Malaysia and the UAE, the extent of application of Islamic principles in the same area is uncertain, as specific provisions on the subject matter have yet to be incorporated in their respective laws or ethical codes (Malaysian Medical Association 2002; UNESCO Cairo Office 2011).

The intervention of law in the area of medicine has been regarded as pivotal, particularly in offering clear guidance in issues that raise ethical, philosophical and religious dilemmas. The law has been seen as a means of controlling the medical profession in the interests of the community as a whole. As advocated by Lord Hoffman in *Airedale NHS Trust v Bland* (“Airedale NHS Trust v. Bland” 1993), “...medical ethics [is] to be formed by the law rather than the reverse” (“Airedale NHS Trust v. Bland” 1993). However, legal intervention in itself may cause problems particularly when the courts may find themselves drawn in to act as mediators in complex and frequently distressing clinical matters. In any event, judges have to make decisions to protect public policy and do justice to both the patient and the doctor.

The judicial courts in Malaysia have yet to decide on issues involving end-of-life decisions; thus, at the moment, such matters are considered to be purely medical decisions (Kassim and Adeniyi 2010; Talib 2002). As the law in this area has yet to reach its fullest extent, the developments in countries such as the UK and the USA have been able to shed light on how conflicting ethical principles are resolved by the courts and the application of different tests in their decisions. Accordingly, their experience would provide invaluable lessons for Malaysia to develop holistic ethical codes that are in congruence with developing legal standards. This is because by virtue of section 3 of the Civil Law Act 1956, due to the lacunae in Malaysian law on end-of-life decisions, English common law and the rules of equity would be applicable as a source of reference for the courts.

The Scope of End-of-Life Care

End-of-life care refers to the health and social care system required to address the physical, social, spiritual and emotional needs of patients who are in the final stages of their lives as well as those who are afflicted with terminal illnesses (Colello et al. 2011; Tallon 2012). From the healthcare perspective, end-of-life care encompasses both palliative care and hospice care, which aim to provide a comfortable environment to restore and improve patients’ quality of life as far as it is practically possible (Centre for Bioethics 2005; Chater and Tsai 2008; Tallon 2012). The World Health Organization defines palliative care as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (World Health Organisation n.d.).

Although both palliative care and hospice care share the same objectives, these two areas should not be confused with one another. Palliative care focuses on reducing the severity of disease symptoms for patients who are seriously ill, and can be delivered along with curative treatment at any time during the course of the patient’s illness (Centre for

Bioethics 2005; Colello et al. 2011). In addition, palliative care is not restricted to patients near the end of life and can be used in both acute and long-term settings (Centre for Bioethics 2005). Hospice care on the other hand is focused on terminally ill patients, who no longer seek curative medical treatment, and is generally offered when the patient is expected to live for 6 months or less (Colello et al. 2011). A salient similarity between palliative care and hospice care is that both involve the mobilisation of an interdisciplinary team of professionals comprising doctors, nurses, social workers and psychologists, with the assistance of chaplains, nutritionists, pharmacists and others (Centre for Bioethics 2005; Colello et al. 2011).

The Ethical Considerations in End-of-Life Care

Conflicting ethical values between healthcare providers and patients may impede the decision-making process in end-of-life care (Carey and Cosgrove 2006; Chater and Tsai 2008; Mazanec and Tyler 2003). On the part of the healthcare provider, respecting the patient's autonomy in the decision-making process may at times be inconsistent with the performance of their ethical obligations of beneficence and non-maleficence. Ethical challenges are further compounded in cases where the patient is incapable of interaction and deciding for himself, whereby family members would stand in as proxy to decide what would have likely been the wishes of the patient pertaining to a certain course of action. The ethical considerations in end-of-life care which have raised ethical dilemmas can be looked at from three aspects:

Withholding and Withdrawal of Medical Interventions

Medical interventions such as resuscitation, ventilators and the use of antibiotics in cases of infection may operate to save and prolong the life of a terminally ill patient. However, such treatments may run counter to the patient's wishes who may request that the same be withdrawn or refuse them altogether. For example, some patients may view cardiopulmonary resuscitation as a death-delaying act, which contradicts with their values and beliefs that one should not alter the course of nature (Markwell 2005; Mazanec and Tyler 2003; Sachedina 2005). In cases where the condition of the patient necessitates respiratory therapy, some patients and family members may view it as a non-beneficial treatment which only serves to impede in what they believe should be the natural process of dying (Centre for Bioethics 2005). Consequently, such patients or their family members may seek a do-not-resuscitate order from their doctor. In such circumstances, doctors are confronted with ethical dilemmas on whether to adhere to the patient's and family members' wishes or to decide on what is the best course of action for the patient. For example, if the decision to withdraw treatment is carried out and death is thereby hastened, would this action violate the ethical principal of non-maleficence which demands that actions taken must prevent harm to the patient? Nevertheless, it has also been argued that it is permissible to withhold or withdraw treatment and allow the disease process to progress to a natural death for the patient (Kinsella and Booth 2007). However, any decision to withhold or withdraw treatment should be based upon the expectation that the patient can no longer benefit from that treatment, it is medically futile and the doctor's intention when doing so must be to relieve the patient of the burdens associated with that treatment (Kinsella and Booth 2007).

Withdrawing medical treatment has always been seen as acceptable as there is a clear distinction between positive acts and omissions. According to the acts–omissions distinction, “in certain contexts, failure to perform an act, with foreseen bad consequences of that failure, is morally less bad than to perform a different act which has the identical foreseen consequences. It is worse to kill someone than to let them die” (Glover 1977). Thus, acting to kill a patient even for good reasons may seem wrong, whereas omitting to act by withholding life-saving treatment may seem right in certain compelling circumstances. It follows that permitting an illness to progress naturally, as opposed to making something happen by acting intentionally, appears to be more acceptable legally and ethically (Glover 1977; McLachlan 2008).

Medical Futility

Medical futility is described as an intervention that will not be able to reach the intended goal of the intervention (Cavalieri 2001). This usually occurs during assessments on whether to forego or withdraw life-sustaining treatments (Centre for Bioethics 2005). The determination of medical futility raises ethical concerns, particularly, on the reasons for considering the treatment as futile. The fact that such decision rests solely in the hands of the healthcare providers may lead to possibilities of the discretion being exercised arbitrarily. For instance, medical treatment may be discontinued not only because it no longer benefits the patient, but such continuation may be considered futile in order to save cost (Centre for Bioethics 2005; Zahedi et al. 2007). Further, discontinuation of life-sustaining treatments particularly artificial nutrition and hydration causes a great deal of ethical tension and emotional burden, especially to the family members of a dying patient (al-Shahri and Al-Khenaizan 2005; Bülow et al. 2008). Food and water are considered to be the basic sustenance of human survival, and denying them to a patient may be viewed by family members as starving their loved one to death (Noah 2006).

However, medical opinions vary on this issue. Some argue that continuing artificial nutrition and hydration prevents suffering to a certain extent, while others claim that it is an unnecessary burden with no clear symptom benefit (Olsen et al. 2010). There are also those that hold the view that nutrition and hydration treatments are palliative care that fulfil a basic human need and should not be denied at the end of life (Centre for Bioethics 2005; Zahedi et al. 2007). However, in some circumstances, the continuous supply of nutrition and hydration may not be beneficial to a dying patient and may in fact be distressing as the patient’s gastrointestinal function deteriorates (Kahn et al. 2003). It is therefore suggested that the principle of proportionality be applied with regard to life-sustaining treatments at end-of-life care. Nutrition and hydration may thus be ethically withheld or discontinued if the dying patient suffers burdens that outweigh the life-prolonging benefit, irrespective of whether death will be the result (Centre for Bioethics 2005).

Pain Management/Terminal Sedation

Terminal sedation is used in end-of-life care to relieve severe suffering. It refers to the use of medications to induce decreased or absent consciousness to the extent that the patient will no longer feel pain, air hunger or other forms of distress (Kahn et al. 2003; Olsen et al. 2010). In the practice of euthanasia, a lethal injection is administered in an amount that is certain to bring about and ultimately intended to cause the death of the patient, while terminal sedation differs from euthanasia in that the dose of medication is maintained rather than increased once sedation is achieved; the intent being not to hasten death but to

relieve suffering (Kahn et al. 2003). Several ethical concerns have been raised, particularly on the unknown effect that terminal sedation may have on hastening death, and the potential abuse of patients who are rendered unconscious during the process, in which right to autonomy is inhibited (Centre for Bioethics 2005; Kahn et al. 2003).

On the risk of exposing patients to a premature death, two major arguments have been forwarded to justify and dispel this notion: firstly being the doctrine of double effect. The double effect doctrine, as applied in medicine, is based on two basic presuppositions: the doctor's motivation is to ease suffering, and the treatment must be proportional to the illness (Malik 2012). The doctrine applies if (1) the desired outcome is judged to be good, e.g. relief of suffering and is not in itself immoral; (2) the bad outcome, e.g. death of patient is not intended even if it is foreseen; (3) the good outcome is not achieved by means of the bad; and (4) the good outcome outweighs the bad (Malik 2012; Markwell 2005). Secondly, it has been argued that the fear that palliative sedation hastens the dying process is unfounded since studies have shown that sedatives administered appropriately and proportionately are able to prolong the chances of survival and improve the quality of life (Centre for Bioethics 2005; Olsen et al. 2010; Tallon 2012).

Further, the effects of pain management also give rise to ethical dilemmas in terms of the patient's cognitive perceptions. Since critically ill patients who are sedated are put into a state of reduced consciousness, this results in the loss of their social interaction. This not only hampers their ability to effectively communicate and partake in any further decision-making process regarding their medical care, but also affects the emotional state of their loved ones. The idea of being put into a deep sleep may not be well tolerated with certain patients and their families whose spiritual belief includes that one should face death with a clear, alert and unclouded state of mind (Keown 2005; Zahedi et al. 2007).

Religious and Spiritual Considerations in End-of-Life Care

In end-of-life care, religion and religious traditions serve two primary functions, namely the provision of a set of core beliefs about life events and the establishment of an ethical foundation for clinical decision-making (Daaleman 2000). Spirituality, on the other hand, revolves around a sense and purpose of life, which may not necessarily involve religious beliefs and practices. Both religion and spirituality support a person's sense of security and belonging, and can be especially significant in end-of-life care, offering the patient a way to find meaning in dying as in life (Chater and Tsai 2008; Daaleman 2000; Mazanec and Tyler 2003). Clinical assessments on quality of life involve the examination of how a patient's illness and well-being are influenced by the patient's physical, social and psychological conditions (Tallon 2012). Thus, the inclusion of measures of religiousness and spirituality into such framework will enable doctors to have a better understanding of patients' beliefs, values, expectations and needs and at the same time facilitate a dynamic interaction between patients, family members and healthcare professionals. Religion and spirituality can potentially mediate quality of life by enhancing a patient's well-being through social support, stress and coping strategies (Daaleman 2000). The following paragraphs outline the different ethical considerations relating to end-of-life care from the Roman Catholic, Jewish, Buddhist and Islamic perspectives in issues such as sanctity of life, withholding and withdrawing of medical interventions and pain management.

The Roman Catholic Perspective

There are two basic human values underlining Catholic bioethics, that is, human dignity, and interconnectedness of every individual to promote a just social order (Markwell 2005; Padela 2006). The value of human dignity stems from the fundamental belief that life is sacred as Catholics believe that they are mere stewards of their human bodies and are therefore accountable to God for the life that they have been given (Markwell 2005; Padela 2006). The value of interconnectedness relates to the relationship and responsibility that each member of society holds towards one another. These two central elements of Catholic bioethics influence end-of-life decisions in the following manner. Firstly, the dignity of the human person, as one who is oriented towards God, requires him or her to make choices for the good within a free and informed conscience; and secondly, the interaction between doctor and patient must take the form of a mutual relationship of trust and respect: the patient trusts that the doctor's intentions and acts are carried out in good faith, and the doctor seeks to understand what the patient's wishes might be (Markwell 2005). Accordingly, Christianity prioritises the significance of patient autonomy and veracity in ethical decision-making. The doctor is under an obligation to provide the patient and family members with the requisite medical information, advice and analysis, but it is ultimately the patient who will decide which treatment or course of action is best aligned with his personal values and beliefs.

In terms of withholding and withdrawing of futile therapy, the Catholic Church allows this to be done if it is burdensome, dangerous, extraordinary or disproportionate to the expected outcome (Bülow et al. 2008). Likewise, the same principle is adopted in cases of pain management or palliative sedation (Bülow et al. 2008; Markwell 2005). While the issue of pain and suffering is important to Catholic bioethics as an opportunity to induce personal growth and gain closeness to God, this belief does not imply that pain relief should be withheld in order that a patient might come to understand the redemptive nature of suffering (Markwell 2005). Christianity allows for the administration of analgesia and sedation to alleviate terminal suffering if this does not, by obtunding consciousness, take away a final chance for repentance (Zahedi et al. 2007). The aforesaid views of the Catholic Church take cognizance of the applicability of the doctrine of double effect in bioethical issues (Bülow et al. 2008; Malik 2012; Markwell 2005), and it is considered to be one of the “most significant principles proposed by all Catholic medical ethicists” (Curran 2008; Malik 2012). Withdrawal of artificial nutrition and hydration from patients at the end of life and for people in a persistent vegetative state, however, is a controversial issue in the Christian faith. In 2004, the then Pope John Paul II issued a pronouncement stating that the cessation of nutrition and hydration resulting in death by starvation amounted to euthanasia which is strictly forbidden (Bülow et al. 2008; Noah 2006). This view has been met with criticism by most bioethicists and medical ethics organisations, as it contradicts much of the Catholic doctrine on matters of end-of-life care (Noah 2006).

The Jewish Perspective

There are three main principles in Jewish medical ethics: life is of utmost value; ageing, illness, and death are a natural part of life; and improvement of the patient's quality of life is a constant commitment (Padela 2006). When applied in the context of end-of-life care, the Jewish position is that dying is a natural part of life's journey that should be addressed with dignity and compassion (Loike et al. 2010) and human beings have both the permission and the obligation to heal (Zahedi et al. 2007). The principle of sanctity of life

connotes that any decision that may directly or indirectly result in hastening death is prohibited. However, Jewish law recognises that “if situations necessitate foregoing certain rules and regulations for a higher purpose, for example, that of saving life or improving quality of life or avoiding harm, then one is allowed to do so” (Padela 2006). According to the Jewish legal system or *Halacha* (which to those of the Jewish faith represents a comprehensive guide to human life, regulating all aspects of behaviour through assigning moral values to actions as well as determining sacred law), there are several basic guidelines related to end of life that distinguish between: (a) acts of omission and acts of commission; (b) treatments pertaining to the dying process (or illness) and treatments unrelated directly to the dying process; (c) treatments that are continuous in nature in which withdrawing of such treatments is considered an act of commission and treatments that are cyclic in nature in which the withholding of the next cycle of treatment is considered an act of omission; and (d) patients who are expected to die within 6 months and those patients with less serious medical conditions (Loike et al. 2010).

Based on the above, on the issue of withholding and withdrawing life-sustaining treatment, Jewish law allows for such act or omission to be carried out only if such treatment is of a recurrent nature and provided that the patient has clearly consented to it. This includes withholding any life-prolonging activities such as intubation, surgery, chemotherapy or dialysis, even after initiation of the same, because such action is viewed as omitting the next treatment rather than committing an act of withdrawal (Bülow et al. 2008). If the same constitutes a continuous form of life-sustaining treatment, for example, a respirator or cardiac pacemaker, then such withdrawal is forbidden. The strictest position in Judaism restricts permission to withdraw or withhold treatment to cases where doctors assume that the patient will die within 72 h (Dorff 2005; Zahedi et al. 2007). Patients and doctors are allowed to withhold or withdraw clinical treatment in cases where the patient is diagnosed with incurable terminal illness, as long as it is within the patient's best interests. Further, the *Halacha* considers oxygen, food and fluids to be essential components of life to which every human being is entitled. Accordingly, a dying patient cannot be denied these basic needs, and withdrawal of artificial nutrition and hydration is not allowed as it is seen as an act leading to death. However, in cases where the continuance of artificial nutrition and hydration cause suffering and complications to a patient who is approaching death, such support may be withdrawn upon the request of the patient or if it can be ascertained that that was the patient's wish (Bülow et al. 2008). The Conservative Movement's Committee on Jewish Law and Standards adopted a somewhat dissimilar view in classifying artificial nutrition and hydration as medicine, permitting their removal where there is not likely to be any reasonable prospect for recovery at the end of life (Zahedi et al. 2007). It is suggested that when the decision is made to discontinue artificial nutrition and hydration, the focus of communication should be on “what will be done to demonstrate respect for the patient, rather than on emphasising what will be withdrawn or withheld” (Gillick 2001; Loike et al. 2010). With regard to palliative sedation, there is a general agreement in Jewish law that this is permitted in spite of the risk that the administration of such drugs may shorten life, based on the principle of double effect (Bülow et al. 2008; Loike et al. 2010).

The Buddhist Perspective

The two most fundamental values in Buddhism are compassion and respect for life (Keown 2005). According to the Buddhist faith, life “begins at conception and ends at death: in the interval between these events, the individual is entitled to full moral respect, regardless of

the stage of psycho-physical development attained or the mental capacities enjoyed” (Keown 2005). The manner of dying and death is of particular significance in Buddhism; death with an unclouded mind is believed to lead to a better rebirth in the next life (Keown 2005; Zahedi et al. 2007), and death is an experience that will recur many times. Consequently, this concept has significant bearing on end-of-life issues such as palliative sedation and pain management, as the concern would be to maintain a mental and sensory clarity at all times. In terms of artificial nutrition and hydration, the Buddhist perspective maintains that such life-sustaining support cannot be discontinued, even from patients in a persistent vegetative state (Keown 2005; Zahedi et al. 2007). This stems from the notion that in Buddhism, damage to the brain is not differentiated from injury to any other part of the human body when considering the ethics of treatment (Keown 2005).

The above does not, however, mean that there is a moral obligation in Buddhism that life must be preserved at all costs. The ethical validity of an act or omission in Buddhism is measured against the aim or motive of such conduct. If a patient “makes death his aim”, then the refusal of medical care is considered to be an offence; declining further treatment due to the patient’s acceptance that recovery is grim and death is inevitable, is on the other hand legitimate (Keown 2005). It follows that proceeding with futile treatment goes against the teachings of Buddhism; “to seek to prolong life beyond its natural span by recourse to increasingly elaborate technology when no cure or recovery is in sight is a denial of the reality of human mortality, and would be seen by Buddhism as arising from delusion and excessive attachment” (Keown 2005).

The Islamic Perspective

The *Shari‘ah* or Islamic law is based on two primary sources, the Holy *Qur‘an* (the Holy Book which Muslims believe to be the word of God Almighty) (*Al-Qur‘an* 2:2) and the *Sunnah* of Prophet Muhammad (peace be upon him) (his words, conduct and tacit approval) (*Al-Qur‘an* 4:59). The secondary source of the *Shari‘ah* is found in *ijtihad* (deductive reasoning) (Sulaiman 2008, Sunan Abu Dawud, Book 24, Hadith no. 3585). The guiding principles, rules and regulations in the main sources govern the Islamic way of life and, together with *ijtihad*, provide a comprehensive moral and juridical framework to address and accommodate issues relating to human conditions (Gatrad and Sheikh 2001). In Islamic jurisprudence, each deliberation towards resolving any given issue must observe the following five fundamental principles which are known as *maqasid al-shari‘ah*: preservation of life, protection of an individual’s freedom or belief, maintenance of intellect, preservation of honour and integrity, and protection of property. Congruently, end-of-life issues in Islamic bioethics involve ethical considerations on the sanctity of human life. This ruling is ordained in the Holy *Qur‘an* in the following verse: “Do not take life which God has made sacred except in the course of Justice” (*Al-Qur‘an* 6:151). It is accordingly forbidden for anyone to deliberately end a life: “Whosoever takes a human life, for other than murder or corruption in the earth, it is as if he has taken the life of all of mankind” (*Al-Qur‘an*: 5:32).

The saving of a life is considered one of the highest merits and imperatives in Islam (Zahedi et al. 2007). Doctors must do everything they can to prevent a premature death. However, this does not come at all costs; when death is inevitable, and clinically evaluated treatment is obviously futile, it ceases to be mandatory (Khan 2002). Islam recognises that there are times in which human beings need to recognise their own limits and let nature take its course (*Al-Qur‘an* 39:42); resorting to futile treatment in order to put off death is not acceptable in Islam (Zahedi et al. 2007). Muslim jurists agree that it is possible for a collective decision to be reached between the attending doctor, patient and family members

to refuse medical interventions and discontinue life-sustaining treatments if such procedures will in no way improve the condition or quality of life, on the basis of informed consent (Bülow et al. 2008; Sachedina 2005; Zahedi et al. 2007). However, if invasive treatment has been intensified to save a patient's life, Muslim jurists have ruled that life-saving equipment cannot be switched off unless the doctor is certain about the inevitability of death (Sachedina 2005).

Islam maintains the position that patients should not be denied their basic human rights of nutrition and hydration even at the end of life. This is due to the fact that withdrawal of such needs would hasten death, which is forbidden in Islam (Bülow et al. 2008; Gatrads and Sheikh 2001; Khan 2002). However, administering analgesia to lessen suffering in end-of-life care is permitted even if in the process, death is hastened, based on the Islamic teaching that "actions are to be judged by their intentions" (Bülow et al. 2008; Gatrads and Sheikh 2001; Sachedina 2005; Zahedi et al. 2007). It follows that the intended purpose of palliative sedation is not to facilitate death, but rather to save a patient from severe discomfort, which renders it ethically legitimate from the Islamic viewpoint.

In Islam, pain is believed to be a form of trial from God to test a Muslim's faith and spiritual standing (*Al-Qur'an* 2:153–7). Muslims should thus endure pain with patience and perseverance, but this does not mean that they are forbidden to seek a means to alleviate the suffering. The Holy *Qur'an* states that "surely the good deeds will drive away the evil deeds [which cause suffering]" (*Al-Qur'an* 11:114); inferentially, this implies the permissibility for a person's endeavour to overcome pain (Albar 2007; Sachedina 2005). This precept is further substantiated by other verses in the Holy *Qur'an* and the *Sunnah* that encourage Muslims to remove harm and difficulty (*Al-Qur'an* 2:185, 5:6 and 94:28; al-Bukhari 1997 (Book 2, Hadith no. 38)). In Islamic ethics, an individual's welfare is intimately linked with his or her family and community (Sachedina 2005). Hence, neither autonomy nor paternalism is the determining factor in deciding a course of action in matters relating to end-of-life decisions, but rather, a joint decision made by all parties associated with the patient, which may require the involvement of religious authorities, if needed (Sachedina 2005).

The Developing Legal Standards

Decision making at the end of life must necessarily take into account the courts' standing on such issues and the legal implications that would ensue. In order for a comprehensive ethico-legal framework to exist where medical codes of ethics are affirmed as good practice, the latter must be compatible with current developments of the law. In the UK, when decisions are made on behalf of a patient, the principle of "best interests" has consistently been the determinative principle in legal cases. A responsible decision by a team of medical experts to withdraw life-sustaining treatments and withhold further medical interventions which have been determined to be futile and would not be in the patient's best interests is permissible under the law and would not subject healthcare professionals to criminal proceedings. This principle was enunciated in the landmark case of *Airedale NHS Trust v Bland* ("*Airedale NHS Trust v. Bland*" 1993), where the House of Lords discussed its legal justification in relation to the principle of sanctity of life and patient autonomy.

The case concerned one Anthony Bland, a victim of the disaster at the Hillsborough Football Stadium who suffered irreversible damage to his cerebral cortex which rendered him in a persistent vegetative state. He was fed artificially and mechanically with a

nasogastric tube and showed no cognitive response to his surroundings. All his natural bodily functions had to be operated with nursing intervention, requiring 4–5 h of nursing attention by two nurses daily. After three and a half years of remaining in this condition, a court declaration was sought by Bland's attending doctor to cease further treatment, which involved extubation, i.e. withdrawal of artificial nutrition and hydration and withholding of antibiotic treatment in case of infection. The declaration was based on a clinical assessment by medical experts that there was absolutely no hope for recovery for Bland and thus any medical intervention would be futile and not in the best interests of the patient. In arriving at its judgement, the court ruled that the principle of sanctity of life was not absolute; "it must yield to the right of self-determination" (per Lord Goff in *Airedale NHS Trust v Bland* ("*Airedale NHS Trust v. Bland*" 1993 at p. 866). The principle of self-determination requires that the patient's wishes be respected to the extent that if a patient of sound mind refuses to consent to a medical treatment which would prolong his life, the doctor responsible for his care must abide by the former's wishes, regardless of the fact that such refusal is unwise.

In the case of an insensate patient like Bland who lacked the capacity to validly consent or refuse medical treatment, the lawfulness of such medical treatment depended upon whether it was in the best interests of the patient (per Sir Thomas Bingham in *Airedale NHS Trust v Bland* ("*Airedale NHS Trust v. Bland*" 1993 at p. 843). The court further held that doctors were not under an unqualified duty to prolong life at all costs; accordingly, the duty to provide medical care "ceases when such treatment can serve no humane purpose" (per Lord Hoffman in *Airedale NHS Trust v Bland* ("*Airedale NHS Trust v. Bland*" 1993 at p. 856). In Bland's case, the futility of the treatment in providing him any quality of life ethically justified its termination (per Lord Goff in *Airedale NHS Trust v Bland* ("*Airedale NHS Trust v. Bland*" 1993 at p. 870).

A patient's right to autonomy was reiterated in *Ms B v An NHS Hospital Trust* ("*Ms B v An NHS Hospital Trust*" 2002). Here, the case involved a patient who was mentally competent and had repeatedly yet unsuccessfully requested for the withdrawal of medical therapy to which she was subjected. Ms B suffered a spinal cavernoma, which necessitated neurological surgery to remove it. During the course of her hospitalisation and treatment, she executed a living will stating that if at any point of time, she was incapable of giving instructions, she wanted treatment to be withdrawn if she was suffering from a life-threatening condition, permanent mental impairment or permanent unconsciousness. Unfortunately, as a result of the surgery, Mrs B became completely paralysed from the neck down and was treated with a ventilator to ease her respiratory problems. She eventually regained some movement in her head and was able to speak, pursuant to which she requested to her clinicians on several occasions to have the ventilator removed. The clinicians were not prepared to do so as they considered it to not be in her best interests, i.e. it would inevitably lead to her death. In allowing Mrs B's claim for a declaration that the hospital had been treating her unlawfully, the court upheld the principle of self-determination, referring to the judgements delivered by the bench in *Airedale NHS Trust v Bland* ("*Airedale NHS Trust v. Bland*" 1993) on the interface between the two conflicting principles of autonomy and preservation of life. It was accordingly ruled that the principle of "best interests" was not applicable in cases where the patient had the mental capacity to make relevant decisions about her medical treatment, and therefore, a doctor was under an obligation to respect the wishes of the patient, even if it was plain to all parties, including the patient, that death would ensue.

The approach to the issue on end of life adopted by the US courts is not entirely dissimilar to the law in the UK (it is noted that although the House of Lords in *Airedale*

NHS Trust v Bland (“Airedale NHS Trust v. Bland” 1993) declined to apply the test of “substituted judgment” used by the US courts in the case of an incapable patient, Lord Hoffman at p. 857 noted that such principle, to the extent that it pays respects to what most likely would have been the patient’s views, “may be subsumed within the English concept of best interests”). In the absence of the expressed wishes of a patient (be it in the form of oral statements or advance directives), decisions are based on the patient’s presumed wishes (Meisel 2008). This is known as the doctrine of “substituted judgement”. Under this doctrine, a surrogate appointed by a patient is legally authorised to make decisions on behalf of the patient, or where there is no surrogate, the patient’s family members, based on the patient’s values and beliefs. This practice marks the difference between the USA and the UK positions; in the UK, it is not a legal requirement for relatives to assent on behalf of a patient who is unable to give consent (per Lord Goff in Airedale NHS Trust v Bland (“Airedale NHS Trust v. Bland” 1993 at p. 872). Discussions with relatives are nevertheless of utmost value because they assist in providing indications about the patient’s own attitudes and values concerning treatment (Kinsella and Booth 2007).

The prolific Florida case of Theresa Marie Schiavo (“Schiavo ex rel. Schindler v. Schiavo” 2005) is noteworthy not only to illustrate the application of the “substituted judgement” test, but also due to the controversial intervention of the executive body and conservative groups in the dispute surrounding her medical care, which attracted intense media coverage. Theresa Schiavo was in a persistent vegetative state for 15 years, following a cardiac arrest. Although she suffered from irrevocable cerebral cortex, she was able to breathe on her own and was kept alive through artificial nutrition and hydration which was delivered by way of a tube implanted in her body. After having accepted the grim medical prognosis that his wife’s incapacity was permanent, Michael Schiavo attempted to seek the court’s permission for the removal of her feeding tube so that she could die peacefully, stating that it would have been against Theresa’s wishes and values to have her life prolonged in a vegetative state with no hope of recovery. Since Theresa Schiavo had not appointed a surrogate, in accordance with Florida law, her husband was authorised to act as the proxy decision-maker, ahead of her other family members (“FLA. STAT. § 765.401(1)” 2005; Noah 2006). In an ensuing series of intense court battles over a period of 7 years, including the controversial intervention of the US Congress, Theresa Schiavo’s parents, Robert and Mary Schindler, fought against Michael Schiavo’s designation as legal surrogate and his request to withdraw the life-sustaining treatment from his wife. Despite immense pressure from political groups, all state and federal courts which heard the case ruled in favour of Michael Schiavo’s application.

In 2004, in what is seen to have been a response to Theresa Schiavo’s case, a pronouncement was made by the then Pope John Paul II concerning the impermissibility of the withdrawal of artificial nutrition and hydration (Bülow et al. 2008; Noah 2006). This was relied on by the Schindlers, arguing that since their daughter was a practising Catholic, she would have been inclined to abide by the papal decree (Noah 2006). Although the courts recognised the relevance of a patient’s religious affiliations, no proper inference could be made as to Theresa’s personal understanding and level of adherence to Catholic principles, and thus, it was difficult to form a decision in that respect (Noah 2006). This highlights the need for a more effective mechanism to facilitate religious and spiritual awareness in end-of-life care, so that ethical and social implications can be “anticipated and acted upon in advance rather than *post factum*” (Steinberg 2003). On that note, it is argued that the legal system is not the most appropriate platform to cope with the different ethical dilemmas created by the dynamic changes in the medical world; instead, multidisciplinary ethic committees may prove to be more efficacious in developing and recommending policies

and procedures to resolve ethical conflict (Steinberg 2003), which are more pronounced at the end of life.

Conclusion

In a world of increasing cultural pluralism and multi-faith societies, there is an undeniable need for those involved in health services to have increased awareness and understanding of the various and distinct value and belief systems of the patients whom they attend to. Sensitivity towards cultural and religious differences leads to increased trust between doctor and patient, resulting in a compassionate and improved end-of-life care environment. Further, aspects of end-of-life care such as withholding and withdrawal of medical interventions, futile treatments and palliative sedation involve a manifold of ethical dilemmas, necessitating a structured approach into the different value systems of each individual patient. It is thus important that healthcare providers inquire into and evaluate a patient's religious and spiritual beliefs as well as his personal attitude towards end-of-life issues such as illness, pain and death. This may accordingly be facilitated through the formulation and implementation of ethical codes which give due consideration to the characteristics of religion, culture and locality. The importance of adequate and effective communication between doctor and patient must also not be underestimated, as it plays a crucial role in minimising misunderstanding and resolving conflict, as well as promoting a mutual and collective approach to decision-making.

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